PRINTED: 12/16/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				PLE CONSTRUCTION IG	COMPLETED	
		445516	B. WING_		C 12/14/2016	
NAME OF	PROVIDER OR SUPPLIER	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		STREET ADDRESS, CITY, STATE, ZIP CODE		
MANAGEMENT.		HABILITATION CENTER		306 W DUE WEST AVE MADISON, TN 37115		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
	(b)(3) Comprehensity The services provide as outlined by the comust- (i) Meet professional This REQUIREMEN by: Based on facility poreview, and interview physician's orders for four residents (#1 residents reviewed for four residents reviewed for the findings included Review of facility polimeters and adverse medical strive to identify and when they occur. The strive to minimize adfollowing relevant climanufacturer's special propriate indication Medical record reviewed mitted to the facility on 11/22/16 with diagonal record reviewed mitted to the facility on 11/22/16 with diagonal record reviewed mitted to the facility on 11/22/16 with diagonal record reviewed mitted to the facility on 11/22/16 with diagonal record reviewed mitted to the facility on 11/22/16 with diagonal record reviewed mitted to the facility of the resident of the facility of the resident of the facility of the f	ed or arranged by the facility, emprehensive care plan, I standards of quality. T is not met as evidenced licy review, medical record v, the facility failed to follow r medication administration 15, #22, #25, #36) of 37 or medication administration. d: lcy, Identifying and Managing d Adverse Consequences, evealed " The staff and o prevent medication errors tion consequences, and shall manage them appropriately e staff and practitioner shall verse consequences by: (a) vical guidelines and fications for use. (b) defining ins for use" v revealed Resident #15 was v on 9/30/16 and readmitted noses including Seizures, povascular Disease, eflux Disease, dent with Hemiplegia, and	F 28	Finding: During a med pass audit completed by the state surveyor of 12/12/16, an incorrect dosage of Remeron was administered to RI #8 RI #36 was assessed by Director of Nursing on 12/13/16 and found to stable vital sign and no signs of distressed observed. MD and family notified on 12/13/16 by the license nurse with no new orders received license nurse has completed a behamonitoring tool daily for December each shift and no signs of depression adverse side effects have been identified as a result of the medicate error that occurred on 12/12/16. RI was re-assessed by MD on 12/15/16 and found to have no negative effect as a result of the medication error. medication error report was completed on 12/12/16. LPN #1 was provided one on one education regarding following the 6 rights to medication administration 12/13/16 by the Director of Nursing Services as well as the Director of Nursing stayed with this Licensed Non 12/13/16 the entire night shift providing direct support and assistant providing direct support and assistant provided of the entire night shift providing direct support and assistant provided direct suppor	have y d The avior on on or discon # 36 cts A eted on	
ROBATORY	IRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNA	TURE	TITLE	(X6) DATE	

Any deficiency statement ending with an asterisk ("benotes" deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to be patients (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			C C	
		445516	B. WING			14/2016	
		HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COL 306 W DUE WEST AVE MADISON, TN 37115		145	
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F 281	Medical record revies Set (MDS) dated 11 was moderately impreview of the MDS required extensive a dressing, and groom feeding and bathing of bowel and bladded Medical record revies 12/6/16 revealed an milligrams (mg) IM (dose)" which was Continued review of revealed orders for "Lasix 20 mg po (dedema"	ew of the 5 day Minimum Data /29/16 revealed Resident #15 paired cognitively. Continued revealed Resident #15 passistance with transfers, ming; was dependent for ; and was always incontinent er. ew of physician's orders dated order for "Lasix 40 intramuscularly) x1 (1 documented as administered. Forders dated 12/7/16 intramuscularly) with the corder of the corder of the corders dated 12/7/16 intramuscularly) with the corders dated 12/7/16 intramuscularly) dated the cord	F 2:	to ensure the nurse performed duties timely and accurately. It was placed back in orientation 12/14/16 with the supervisory observation of another license until she is able to demonstrate Medication Administration competencies. This Licensed It currently continues to have acclicense nurse supervision. Finding: During a MAR check completed on 12/13/16 by the staff as part of the QA process identified an order for Lasix da 12/7/16 was missed on 12/10/RI #15 was assessed by the licenurse on 12/12/16 and found the staff and staff as part of the licenurse on 12/12/16 and found the staff as part of the QA process identified an order for Lasix da 12/7/16 was missed on 12/10/RI #15 was assessed by the licenurse on 12/12/16 and found the staff as part of the QA process identified an order for Lasix da 12/7/16 was missed on 12/10/RI #15 was assessed by the licenurse on 12/12/16 and found the staff as part of the QA process identified an order for Lasix da 12/7/16 was missed on 12/10/RI #15 was assessed by the licenurse on 12/12/16 and found the staff as part of the QA process identified an order for Lasix da 12/7/16 was missed on 12/10/RI #15 was assessed by the licenurse on 12/12/16 and found the staff as part of the licenum the staff as part of the QA process identified and order for Lasix da 12/7/16 was missed on 12/10/RI #15 was assessed by the licenum the staff as part of the licenum the staff as part of the QA process identified and order for Lasix da 12/7/16 was missed on 12/10/RI #15 was assessed by the licenum the staff as part of the licenum the licenu	This nurse n on to nurse te nurse dditional e facility tit was ted f16.		
	with the Lasix 40 mg	IM documented as		normal vital signs and remaine	d in		
	administered on 12// review revealed Las daily was documente scheduled for 9:00 A off. Further review re undated, with Lasix 2 scheduled for 9:00 A administered on 12/6 12/12/16. Medical record review 12/13/16 revealed " Lasix 20 mg PT daily	8/16 at 3:00 PM. Continued ix 20 mg one tab by mouth ad on the MAR and all but no doses were signed evealed a second MAR, 20 mg PT (per tube) daily and documented as 8/16, 12/9/16, 12/11/16, and a v of nursing notes dated a Noted resident not getting ordered on 12-7-16, (named are and new order to start		stable condition. MD was notified 12/13/16 of the identified mederror and new orders received follow up chest X-ray was completely 12/14/16 with no pleural effus were detected and results report the MD. A new order was receded to Lasix on 12/14/16. Family was notified on 12/13/16 of medication changes and X-ray RI #15 was re-assessed in personal	ied on dication A pleted on ions orted to eived to was ation results. on by MD		
		w of the MAR for December		on 12/15/16 and found to be in condition with no observed neg			

Fac outcome as a result of the missed medication.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	COMPLETED		
		445516	B. WING		C 12/14/2016	
ALAME OF	PROVIDER OR SUPPLIER	443310		TREET ADDRESS, CITY, STATE, ZIP CODE		
		HABILITATION CENTER	3	06 W DUE WEST AVE MADISON, TN 37115		
(X4) ID PREFIX TAG	(FACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPIDEFICIENCY)	BE COMPLETION	
F 281	PT daily x5 days wit initialed as administ (discontinued). Medical record reviet 12/13/16 at 5:53 PM MAR lasix found to Continued review of note from the Unit M writer notified MD of number of days med to D/C lasix" Medical record reviet admitted to the facili including Chronic Ot Disease, Hypertensi	all record review reveled Resident #22 was ed to the facility on 12/24/14 with diagnoses ng Chronic Obstructive Pulmonary e, Hypertension, Peripheral Vascular		LPN #2 has not worked since this occurrence was identified. LPN #2 receive one on one education from Director of Nursing/Designee regathe expectation of following the Norders regarding medication administration prior to returning twork. Finding: During a MAR to physicial order audit completed by the facilistaff as part of the QA process on 11/29/16, it was identified that are order written for Plavix was not transferred to the MAR and there not administered to the resident. During survey exit it was brought attention that there was a MD	n arding AD ardi	
	dated 9/3/16 revealed Interview for Mental indicating the resider cognitively. Medical record review 1/27/15 revealed an imilligrams (mg) twice blood pressure) < (le blood pressure) < 60 Medical record review 2016 revealed on 11/20 pressure was 104/50 there was no document.	e daily; hold for SBP (systolic ss than) 100; DBP (diastolic ; apical heart rate <60. w of the MAR for November 25/16 Resident #22's blood . Continued review revealed entation on the MAR the Further review revealed no		parameter to hold Propranolol for <60 for RI # 22 and upon MAR rev was identified that the nurse obta BP on 11/22/16 of 113/54 as well 11/25/16 BP of 104/50 and on boto occasions it was noted no evidence where the medication was held as directed per the parameters. Note telephone order had been receive since the above occurrences to on include SBP and pulse parameters Propranolol as of 11/30/16.	view it ined as on the ce sed MD add	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION		E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			1	PLETED
10			D MINO		C 12/14/2016	
		445516	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	121	14/2010
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 21F CODE		
CREEKS	SIDE HEALTH AND RE	HABILITATION CENTER		MADISON, TN 37115		
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F 281	administering the mythen a medication nursing notes reveal medication was held buring interview on conference room, the confirmed the DBP was not held per physical record reviet Disease consult dat "Doppler shows or artery. American He Plavix as alternative Cerebrovascular Active Myocardial Infarction Disease patients"	sedication as is the standard is held. Continued review of alled no documentation the d. 12/13/16 at 1:27 PM in the ne Director of Nursing (DON) was <60 and the medication ysician orders. We of a Peripheral Vascular ed 11/15/16 revealed colusion of left posterior tibial part Association recommends to Aspirin in reducing risk of cident, Vascular Death, and in Peripheral Arterial	F 281	RI #22 was assessed by licensed non 11/29/16 and found to have st vital signs with no evidence of any negative outcomes as a result of t medication error. MD and family notified of medication error on 11/29/16. Follow-up labs will be completed as ordered by MD to e effectiveness of the medication. On 11/29/16, a medication variance of was completed by the Director of Nursing. RI #22 was re-assessed in person by MD on 12/15/16 and for to have not experienced any discover clinical issues that would be a concern to the resident's overall hand safety.RI #22 vital signs noted 11/22/16 @ 8pm to be stable at 1	able he nsure On eport und omfort health on	
	for the resident's Pe Medical record revie 11/29/16 revealed " error r/t (related to) F assessed with no sid (new order) written to (daily).	order for Plavix 75 mg daily ripheral Arterial Disease w of nursing notes dated Physician notified of med Plavix order. Resident le effects R/T med error. NO begin Plavix 75 mg QD		and pulse of 60 and on 11/25/16 (8pm to be stable with a BP of 110, and pulse of 72. Noting no negative outcome as a result of the medical error. A medication variance report completed on 12/15/16 by the Dirof Nursing. MD and family notified medication error on 12/15/16 by	@ /64 /e tion rt was rector	
	failed to follow physic and failed to adminis 11/29/16. Medical record reviev admitted to the facilit	e DON confirmed the nurses cian's orders for the Plavix ter the Plavix from 11/17/16 - w revealed Resident #25 was y on 4/20/16 and readmitted tees including Congestive		licensed nurse. RI #22 was re-asse in person by MD on 12/15/16 and found to have not experienced an discomfort or clinical issues that w be a concern to the resident's ove health and safety.	y ould	

STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPLE CONSTRUCTION		E SURVEY IPLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING		C
		445516	B. WING		1130000	14/2016
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				306 W DUE WEST AVE		
CREEKS	SIDE HEALTH AND RE	HABILITATION CENTER		MADISON, TN 37115		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 281	Heart Failure, Diabetes Mellitus, Peripheral Vascular Disease, Lymphedema, Chronic Kidney Disease Stage IV, Hypertension, and Gastroesophageal Reflux Disease. Medical record review of the Quarterly MDS dated 10/25/16 revealed Resident #25 scored 15 on the BIMS indicating she was alert and oriented. Continued review revealed Resident #25 required extensive assistance with transfers, dressing, grooming, and bathing; assistance with eating; and was always continent of bowel and bladder. Medical record review of physician's orders dated 11/30/16 revealed Resident #25 was ordered Ultram 50 mg daily. Medical record review of nursing notes dated 12/13/16 for a late entry on 12/12/16 revealed		F 2	81 LPN #6 was provided or education by Quality As on 11/29/16 regarding medication administrat transcription of physicial expectation regarding standards of practice. LPN #6 was provided or education on 12/15/16 Nursing/Designee regarding physician orders, transcription as a result of the Director of Nursing monitored and reviewer compliance with medication and reviewer compliance with the reviewer compliance with the reviewer compliance wit	ssurance Nurse 6 rights to ion, an orders and professional ne on one by Director of rding following cription and sult of the an error. LPN #6 mance f 12/15/16 by and will be d weekly for	
	12/10/16 and 12/11/10 omitted. Daughter & Review of the Narcot the resident's Ultram out for 12/10/16 and During interview on 1 conference room, the Ultram were not sign being administered of Medical-record review admitted to the facility on 4/1/16 with diagnon Hypertension, Dysphall, Depression and Pe	MD notified of med errors" ic Administration Record for revealed no doses signed		administration, Physicial transcription. Finding: An order for U 11/30/16 was not available later due to not having copy of the order. RI #25 with a BIMS scor assessed per shift for pathe arrival of the Ultran #25 has had no complain	Itram written on able until 4 days a hard written ee of 15 is ain levels. Since	

CTATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING		COL	TE SURVEY MPLETED
ANDID	0. 0	145546	B. WING			C /14/2016
1	PROVIDER OR SUPPLIER	445516 EHABILITATION CENTER	3	STREET ADDRESS, CITY, STATE, ZIP CO 306 W DUE WEST AVE MADISON, TN 37115		() Time is
(X4) ID PREFIX TAG	SUMMARY STA	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLÉTION DATE
	order dated 9/9/16 f 15 mg (milligram) ta mouth at bedtime da Observation of Licer #1 on 12/12/16 at 11 revealed the LPN ac tablets to the resider Interview with LPN # the Hermitage Nurse confirmed she had g instead of 1 (one) 7.5 Interview with the Dir 12/14/16 at 3:10 PM confirmed LPN #1 ga	for Remeron (antidepressant) ablet give ½ tablet (7.5 mg) by laily. Insed Practical Nurse (LPN) 1:10 PM in the resident's room dministered 2 (two) 7.5 mg Int. If on 12/13/16 at 12:10 AM at e Station and medication cart given 2 (two) 7.5mg tablets 5mg tablet to Resident #36. Irector of Nursing (DON) on In the conference room ave the wrong dosage of int #36 on 12/12/16, and failed	F 281	#25 was assessed by the Nur Practitioner on 12/7/16 regarefusal of medications and redistress with no mention of Osteoarthritis or generalized issues. RI #25 was assessed by license nurse and found the effective pain management place with no lasting negative from the medication error. The resident pain level was assed to person by 12/15/16 and noted resident stable with no discomfort of issues that would be a concresident's overall health and the LPN #3 received educations on 12/12/16 by Quality Assentation of medicative administration and expectation of medicative obtaining meds unavailable ordered by a physician with expectation of continued Muntil the script is obtained.	d pain on 12/11/16 to have control in ve affected The essed by the rel. RI #25 by the MD on nt to be or clinical ern to the d safety. al counseling urance r proper on otions of e when in the MD follow-up	
			181			

CTATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	B. WING		C 12/14/2016	
1	PROVIDER OR SUPPLIER	HABILITATION CENTER	S 3	TREET ADDRESS, CITY, STATE, ZIP CODE 06 W DUE WEST AVE 1ADISON, TN 37115		
(X4) ID PREFIX TAG	SUMMARY STA	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	15 mg (milligram) to mouth at bedtime do Observation of Licer #1 on 12/12/16 at 11 revealed the LPN at tablets to the resider Interview with LPN # the Hermitage Nurse confirmed she had ginstead of 1 (one) 7.5 Interview with the Dir 12/14/16 at 3:10 PM confirmed LPN #1 games.	or Remeron (antidepressant) blet give ½ tablet (7.5 mg) by aily. ased Practical Nurse (LPN) :10 PM in the resident's room lministered 2 (two) 7.5 mg at. 1 on 12/13/16 at 12:10 AM at e Station and medication cart iven 2 (two) 7.5mg tablets formg tablet to Resident #36. ector of Nursing (DON) on in the conference room ive the wrong dosage of t #36 on 12/12/16, and failed	F 281	LPN #4 received educational countries on 12/12/16 by Quality Assurance Nurse regarding process for proper documentation of medication administration and expectations of obtaining meds unavailable when ordered by a physician with the expectation of continued MD follow until the script is obtained. LPN #5 was a temporary contract and her contract was terminated of 12/6/16 and no longer works at the facility. Finding: It was reported during the survey that a complaint was called alleging that an improper tube feed was administered. On 12/6/16, the	f nurse on e lin ding	
				agency nurse indicated an improportube feeding had been identified ther, but she did not disclose specific resident. RI #5 (None identified RI for survey was assessed by licensed nurse on 11/30/16 and found to have no negative nutritional affects as a resof receiving the incorrect feeding. Incorrect feeding was immediately removed when observed to be incomed replaced with correct nutritions supplement as ordered by physicia #5 was assessed by the MD on	ey) sult orrect nal	

CTATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING	3	С
		445516	B. WING		12/14/2016
	PROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 306 W DUE WEST AVE MADISON, TN 37115	
(X4) ID PREFIX TAG	SUMMARY STA	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) 12/15/16 and found to be stable w	RIATE COMPLETION
	order dated 9/9/16 ff 15 mg (milligram) ta mouth at bedtime do Observation of Licer #1 on 12/12/16 at 11 revealed the LPN actablets to the resider Interview with LPN # the Hermitage Nurse confirmed she had ginstead of 1 (one) 7.5 Interview with the Dir 12/14/16 at 3:10 PM confirmed LPN #1 ga	or Remeron (antidepressant) ablet give ½ tablet (7.5 mg) by aily. ased Practical Nurse (LPN) 1:10 PM in the resident's room aministered 2 (two) 7.5 mg at. 1:10 n 12/13/16 at 12:10 AM at a Station and medication cart aiven 2 (two) 7.5mg tablets aministered to Resident #36. The conference room are the wrong dosage of at #36 on 12/12/16, and failed	F 281	no negative outcomes as a result of	f tion n cian an port
	*			are being followed as evidence by completed Medication Administration Record. No other transcription errowere identified and medication administration records were completed as ordered. As of 12/6/16 when we were made aware of this issue by the Agency not a 100% audit was conducted to verified and residents that receive enteral feeding were being providing the appropriate feeding according to the physician orders. No residents were identified to have incorrect enteral	ion eted urse ify
1	(AC DO) Provious Versions Obs	solele Event ID: 0GRH11	Facil	feedings provided.	et Page 6 of 6

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			COMPLETED		
		445516		B. WING			12/14/2016	
1	PROVIDER OR SUPPLIER	HABILITATION CENTER		30	TREET ADDRESS, CITY, STATE, ZIP CODE 06 W DUE WEST AVE ADISON, TN 37115			
(X4) ID PREFIX TAG	SUMMARY STA	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
	15 mg (milligram) to mouth at bedtime dobservation of Lice #1 on 12/12/16 at 1 revealed the LPN at tablets to the reside Interview with LPN # the Hermitage Nurse confirmed she had ginstead of 1 (one) 7. Interview with the Dita/14/16 at 3:10 PM confirmed LPN #1 or	for Remeron (antidepressant) ablet give ½ tablet (7.5 mg) by aily. Insed Practical Nurse (LPN) I:10 PM in the resident's room diministered 2 (two) 7.5 mg int. I:10 n 12/13/16 at 12:10 AM at a Station and medication cart given 2 (two) 7.5mg tablets 5mg tablet to Resident #36. Irector of Nursing (DON) on in the conference room ave the wrong dosage of at #36 on 12/12/16, and failed	F2	81	Pharmacy Nurse Consultant has be conducting Medication Administration Diservations of at least 5 license in weekly since the first of November MAR to Cart checks on 100% of the carts each week since the 2 nd week November. 3) Regional Clinical Director/Designed provided education to Nursing Administration Team to include Director of Nursing, Unit Manager, Quality Assurance Nurse, MDS Coordinator, Night Shift RN Superving Medication Administration Record and Treatment Administration Record turnover/end of month proon 12/16/16. In addition the Corporations of the conduction of the corporation o	tion nurses r and e c of visor: fon tion occess		
		5		State of the state	Support team members will assist the turnover/end of month process monthly X 6 months to ensure account and competencies. Director of Nursing/Designee begated ducation to licensed staff on 12/1 regarding 6 rights to medication administration, Medication transcription process, ordering and receiving medications, following physician orders, documentation a professional standards. Education continued until 100% of licensed in have been educated.	with es uracy n re5/16 d nd to be		

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CTATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	B. WING		J113	C 14/2016	
1	PROVIDER OR SUPPLIER	445516 HABILITATION CENTER	1 5	STREET ADDRESS, CITY, STATE, ZIP CODE 106 W DUE WEST AVE MADISON, TN 37115	1.27	14/2010	
(X4) ID PREFIX TAG	VEACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE	
	Continued From page 5 order dated 9/9/16 for Remeron (antidepressant) 15 mg (milligram) tablet give ½ tablet (7.5 mg) by mouth at bedtime daily. Observation of Licensed Practical Nurse (LPN) #1 on 12/12/16 at 11:10 PM in the resident's room revealed the LPN administered 2 (two) 7.5 mg tablets to the resident. Interview with LPN #1 on 12/13/16 at 12:10 AM at the Hermitage Nurse Station and medication cart confirmed she had given 2 (two) 7.5mg tablets instead of 1 (one) 7.5mg tablet to Resident #36. Interview with the Director of Nursing (DON) on 12/14/16 at 3:10 PM in the conference room confirmed LPN #1 gave the wrong dosage of Remeron to Resident #36 on 12/12/16, and failed to follow the physician's order.		F 281	All new hired license staff to receivarientation education by the Dire Nursing/Designee to include 6 right medication administration, medications, ordering and receivaries medications, following physicians documentation, and professional standards. Director of Nursing/Designee to conduct Medication Administration Observations to validate compete with following physicians orders, documentation & administration unrses per day to include both shi daily X 14 days, then 5 license nur per week X 2 weeks, then 10 licen nurses per month X 2 months or unreasonable in the Director of the Director of Nursing/Designee to conduct Medication Administration of the Director of Nursing/Designee to conduct Medication Administration of the Director of Nursing/Designee to conduct Medication Administration of Nursing/Designee to conduct Medication Administr	the Director of ide 6 rights to in, medication direction direction orders, essional orders, essional orders, estration with 2 both shifts ense nurses		
				sustained compliance can be read Pharmacy Nurse Consultant to consultant additional medication administrate observations weekly. Pharmacy Nurse Consultant to consuce a complete MAR to cart check twice weekly X 4 weeks to ensure availation and accuracy of medication to be administered according to physicity orders.	nduct cion nduct ce ability		

Event ID: 0GRH11

PRINTED: 12/16/2016 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

CTATEMEN	NT OF DEFICIENCIES OF CORRECTION	CIES (X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C 12/14/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 306 W DUE WEST AVE MADISON, TN 37115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRIDEFICIENCY)	JLD BE COM	(X5) IPLETION DATE
F 281 Continued From order dated 9/9, 15 mg (milligrar mouth at bedtim Observation of I #1 on 12/12/16 revealed the LP tablets to the result of 1 (one instead of 1 (one instead of 1 (one instead LPN #Remeron to Resident end of Resident end in the I instead of 1 (one instead of 1 (o	order dated 9/9/16 15 mg (milligram) to mouth at bedtime of Observation of Lice #1 on 12/12/16 at 1 revealed the LPN at ablets to the reside Interview with LPN at the Hermitage Nurse confirmed she had ginstead of 1 (one) 7. Interview with the Difference with the Difference IPN #1 gentlemed LPN	for Remeron (antidepressant) ablet give ½ tablet (7.5 mg) by laily. Insed Practical Nurse (LPN) 1:10 PM in the resident's room dministered 2 (two) 7.5 mg Int. #1 on 12/13/16 at 12:10 AM at e Station and medication cart given 2 (two) 7.5mg tablets 5mg tablet to Resident #36. I rector of Nursing (DON) on in the conference room ave the wrong dosage of int #36 on 12/12/16, and failed	F 281	The Pharmacy will place an addition First Dose Medication Cart on the term Care Unit when the cart and The Cart will be ordered the west 12/19/16. Regional Clinical Director/Corposupport to provide clinical overse conduct validation audits of Medication Administration, Medication Administration and Enteral Feed accuracy daily for 1 week then week for 4 weeks, then weekly usustained compliance can be read Director of Nursing/designee to conduct an audit of 100% of phyorders daily to ensure proper transcription of physician order.	ne Long rives. ek of rate ite dication ing 5 days a intil iched.	
				occurred. On the Weekends the Manager working will conduct the audits. These audits will include the limited to medication orders the management to ensure medication received and available to be administered as ordered per phy orders.	out not for pain ons are	
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CTATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING		С	
		445516	B, WING		12/14/2016	
Į.		HABILITATION CENTER	30	TREET ADDRESS, CITY, STATE, ZIP CODE 06 W DUE WEST AVE ADISON, TN 37115 PROVIDER'S PLAN OF CORRECTION	V (X5) BE COMPLETIC	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETIC	
	order dated 9/9/16 from 15 mg (milligram) ta mouth at bedtime date of the LPN and tablets to the resider of the LPN # the Hermitage Nurse confirmed she had go instead of 1 (one) 7.5 Interview with the Director of the LPN # 12/14/16 at 3:10 PM confirmed LPN # 1 garage.	blet give ½ tablet (7.5 mg) by billy. Insed Practical Nurse (LPN) Insed Practical Nurs	F 281	Director of Nursing/Designee to conduct an audit of 24 hour chart to validate compliance. Audit to be conducted daily X 14 days, then 5 per week X 2 weeks, then 10 days month X 2 months or until sustain compliance can be reached. Director of Nursing/Designee to conduct an audit of residents that receive enteral nutrition to ensure physician orders are being followed audits to be done daily X 14 days, 5 days per week X 2 weeks, then 1 residents per months X 2 months until sustained compliance can be reached. The Administrator hired an additional conduction of the surface of the surfa	days per ned then to or	
	901			Director of Nursing who is schedul start date of 12/26/16. The Administrator will continue to aggressively recruit and hire complicense staff to resolve the use of agency staffing and maintain conscontinuity of care. Nine new nurse scheduled to start orientation with the next 2 weeks on 12/19/16 for starting orientation and a addition scheduled to start 12/26/16. The new nurses will receive orientation individual needs orientation time scheduled.	ocetent sistent es are hin ur nal-5	

CTATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A BUILDING		C		
445516			B. WING STREET ADDRESS, CITY, STATE, ZIP CODE		1 12	12/14/2016	
1	PROVIDER OR SUPPLIER		306 W DUE WEST AVE				
CREEKSIDE HEALTH AND REHABILITATION CENTER			MADISON, TN 37115				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	ULD BE COMPLETION		
	Continued From page 5 order dated 9/9/16 for Remeron (antidepressant) 15 mg (milligram) tablet give ½ tablet (7.5 mg) by mouth at bedtime daily. Observation of Licensed Practical Nurse (LPN) #1 on 12/12/16 at 11:10 PM in the resident's room revealed the LPN administered 2 (two) 7.5 mg tablets to the resident. Interview with LPN #1 on 12/13/16 at 12:10 AM at the Hermitage Nurse Station and medication cart confirmed she had given 2 (two) 7.5mg tablets instead of 1 (one) 7.5mg tablet to Resident #36. Interview with the Director of Nursing (DON) on 12/14/16 at 3:10 PM in the conference room confirmed LPN #1 gave the wrong dosage of Remeron to Resident #36 on 12/12/16, and failed to follow the physician's order.		F 281	Director of Nursing/Designee to present audit findings to the Quality Assurance Performance Improvement Committee meeting every other week X 6 months or until sustained compliance is reached. The Quality Assurance Performance Improvement Committee to include but not be limited to the following: Administrator, Medical Director, Director of Nursing, Unit Managers, MDS Coordinator, Business Office Manager, Social Service Director, Activity Director, Dietary Manager, House Keeping Supervisor and Maintenance Supervisor.			
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